Supreme Court, U.S.
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No. 97-225

In the

Supreme Court of the United States

October Term, 1997

DIANNE L. SHEA, Individually and as Trustee for the Heirs of Patrick Joseph Shea, Decedent; Individually And Derivatively on Behalf of Participants in the Seagate Group Health Plan,

Petitioner,

vs.

SIDNEY ESENSTEN, JEFFREY A. ARENSON; FAMILY MEDICAL CLINIC, P.A., n/k/a FAIRVIEW CLINICS, A Minnesota Non-Profit Corporation; and MEDICA, A Minnesota Non-Profit Corporation,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals For the Eighth Circuit

RESPONDENT MEDICA'S BRIEF IN OPPOSITION

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PARTIES TO THE PROCEEDING

The petition accurately lists the parties to the proceeding.

Respondent Medica, a non-profit corporation, is the wholly-owned subsidiary of Allina Health System, a non-profit corporation. There are no non-wholly owned subsidiaries of Allina Health System.

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STATEMENT OF THE CASE

Petitioner attempts to have this Court hear and decide issues never addressed by the Eighth Circuit Court of Appeals or the district court below, which could significantly impact how health plans are administered and regulated nationwide. Despite citing no prior court decision adopting her position, let alone any ruling by any court in this case, petitioner argues that an HMO should be subject to liability under state common law theories for failure to disclose the structure of physician financial arrangements with the HMO, on the novel theory that such activities relate to "quality of care" as opposed to "plan administration" for purposes of ERISA preemption. In so arguing, petitioner relies upon many facts and circumstances not yet resolved in this case. Indeed, there have been no factual findings by any lower court because petitioner is appealing from the district court's summary dismissal of her complaint pursuant to Fed. R. Civ. P. 12(b)(6). *See* Petitioner's Appendix ("App.") at 27A. How this Court, without the benefit of any lower court decision or any factual record, could address factual issues relating to what services were provided by the Medica HMO to Mr. Shea's health plan, and then determine whether such services could relate to the "quality of care" provided to Mr. Shea as opposed to plan administration, is difficult to imagine at best. Petitioner's novel and fact-oriented arguments at this late stage in the appeal process do not warrant this Court's review.

Medica adamantly disagrees with petitioner's view of Medica's financial arrangements with defendant Fairview Clinic, the entity which employed the physicians treating Mr. Shea. At the district court below, the parties are now

engaged in lengthy discovery as to the content and meaning of Medica's contract with the Fairview Clinic, and whether there were any financial disincentives for clinic physicians to provide good care to Mr. Shea. Medica intends to show through such discovery that:

1) The financial arrangement between Medica and the Fairview Clinic encouraged good quality health care, not inadequate care as alleged by petitioner;

2) There was no "penalty" to Mr. Shea's physicians in the event of a referral to a specialist, such as a cardiologist;

3) Mr. Shea's physicians in fact referred Mr. Shea to a specialist for care – a gastroenterologist – which was reasonable in light of Mr. Shea's symptomology;

4) The compensation of the physicians treating Mr. Shea was not impacted by any referral or lack of referral; and

5) In treating Mr. Shea, the physicians were not even aware of what health plan Mr. Shea belonged to.

These facts, among others, will demonstrate to the district court that there was no "material" disincentive for Mr. Shea's physicians to provide good care to Mr. Shea. This is exactly the kind of factual inquiry contemplated by the Eighth Circuit's decision, focusing on the issue of whether Medica failed to disclose a "material fact" of Mr. Shea's health plan under ERISA. App. 37A. There is nothing in the petition which suggests that the Eighth

Circuit's directives to the parties and the district court under ERISA should be disturbed by this Court at this time. No further review of the Eighth Circuit's decision is required, particularly without further factual development at the trial court level.

Moreover, petitioner's "quality of care" argument, while not addressed by either the trial court or the Eighth Circuit, is without merit. In ruling that petitioner's state law claims were preempted by ERISA (in the context of deciding whether petitioner's complaint was properly removed by Medica to federal court under ERISA), the trial court properly concluded that petitioner's claims related to Medica's responsibilities as plan administrator:

> The misrepresentations alleged in this case have a connection to the plan. If the deceased had not enrolled in the Medica plan, Medica would have had no duty whatsoever to the deceased, let alone the alleged duty to disclose to him its financial arrangements with its health care providers. If the misrepresentation counts were allowed to proceed, it could be necessary to determine the benefits to which the deceased was entitled under the plan, the benefits he might have been promised, and the benefits he actually received. Furthermore, the deceased consulted the defendant doctors because they were associated with the plan. Finally, if the state law causes of action were allowed to go forward and were successful, the disclosure requirements for plan administrators like Medica would be affected

> if they attempted to avoid similar liability under state law in the future. These causes of action could not be resolved without reference to the employee benefit plan under ERISA.

App. 4A.

Although ruling without the benefit of petitioner's new "quality of care" argument, it is unlikely that the trial court would have reached a different conclusion. The trial court was correct that petitioner's state common law claims against Medica have a sufficient "connection to" Medica's responsibilities as plan administrator for purposes of ERISA preemption. This decision was affirmed by the Eighth Circuit. App. 33A-34A. Petitioner's "quality of care" argument was not timely presented to the trial and appellate courts in this case, and does not in any event raise substantial doubt as to the correctness of either the trial court or appellate court rulings.

REASONS THE WRIT SHOULD BE DENIED

A. The petitioner presents new issues not raised or preserved below.

The petitioner asks this Court to decide whether the "quality of care" provided by an HMO is a "benefit" of an ERISA plan:

> The key inquiry is whether contracts between an HMO and doctors are part and parcel of the administration of an ERISA plan. If so, then ERISA preempts State law claims that challenge the quality of care resulting from such contracts. If not, then the State law claims can proceed as the stuff of State health insurance and tort law of general applicability. . .

Petition at 15. In essence, the petitioner asks this Court to graft onto ERISA the distinction between plan administration and "provision of quality health care" — a distinction that was never addressed by either the trial court or appellate court below. Petitioner should not be allowed to raise new issues at this late stage of the appeal process.

The distinction urged by the petitioner appears nowhere in the statute. Neither was such a distinction addressed by the Eighth Circuit, where petitioner presented only the following issue (App. 30A):

> Whether ERISA preempts a state tort action against an ERISA fiduciary for tortious interference with the doctor-patient relationship and for fraud?

In direct response to this issue, the Eighth Circuit concluded that "claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision." App. 34A. The decision of the court of appeals reveals no judgment on the novel theory here that ERISA recognizes the "dual role" of HMOs as both plan administrators and health care providers. Because the issue presented by the petitioner cannot be extracted from the opinion below, it cannot provide a basis for a writ of certiorari. *See Delta Airlines Inc. v. August*, 450 U.S. 346, 362 (1981).

There is no basis for this Court to accept review of the Eighth Circuit's decision. At a minimum, petitioner's novel "quality of care" argument should have been addressed by the trial court and the Eighth Circuit below in order for this Court to grant the petition.

1. **Even if petitioner's arguments had been squarely presented to the Eighth Circuit, she failed to properly appeal from the district court's dismissal of her state law claims.**

With respect to petitioner's request before this Court for reinstatement of her state law claims, there is substantial doubt that petitioner appealed from the correct order of the district court. Petitioner's notice of appeal failed to identify the district court's April 22, 1995 order dismissing her state common law tort claims on grounds of ERISA preemption. App. 28A-29A. Instead, her notice of appeal identified only the October 14, 1994 order denying her motion to remand and the November 15, 1995 order dismissing her ERISA

claims. "Omission of any reference to the order appealed from is more than a technical deficiency; it creates a jurisdictional bar to the appeal." *Davenport v. Riverview Gardens Sch. Dist.*, 30 F.3d 940, 946 (8th Cir. 1994); *see also Klaudt v. United States Dep't. of Interior*, 990 F.2d 409, 411 (8th Cir. 1993).

Since petitioner did not notice an appeal from the order dismissing her state common law tort claims based on preemption grounds, appellate jurisdiction in the first instance is questionable. Petitioner only appealed from the order of the trial court holding that her state court complaint was properly removed to federal court under ERISA. This jurisdictional defect renders the case an inappropriate vehicle for addressing the ERISA preemption issues raised by petitioner with respect to the revival of her state law claims.[1]

B. There is no conflict in the circuits on the questions presented in the petition.

There is no conflict in the circuit courts with regard to the issue of whether an HMO's failure to "deliver quality

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[1] The petitioner's designation of the ERISA preemption issue in her Form A did not cure the defect. The preemption question presented in the Form A refers to the October 14, 1994 order removing the case to federal court, and not to the subsequent dismissal of her state law claims on April 22, 1995. Even the Eighth Circuit acknowledged the distinction by making it quite clear that it was considering the preemption issue only in the context of removal:

> *Having decided Mrs. Shea's case belongs in federal court,* we turn to Medica's contention that Mrs. Shea lacks standing to pursue an ERISA remedy.

App. 34A-35A.

health care services" is or is not a claim preempted by ERISA. Petitioner misconstrues the circuit court decisions cited in her petition, and fails to recognize that she has never asserted a medical malpractice claim in this case — a fatal flaw for purposes of a medical malpractice or "quality of care" analysis under ERISA.

Certiorari is appropriate when a court of appeals "has rendered a decision in conflict with the decision of another United States court of appeals *on the same matter*." Supreme Court Rule 10.1(a). Mere inconsistency in general principles emphasized or relied upon by the courts of appeals applying ERISA preemption in a variety of contexts does not, in and of itself, make this case the appropriate vehicle for resolution of a question not squarely presented elsewhere.

In asserting a conflict in the circuits, petitioner points to two decisions addressing medical malpractice claims against HMOs. Neither is applicable to the issue that petitioner attempts to raise here. In both *Dukes v. U. S. Healthcare*, 57 F.3d 350 (3d Cir. 1995), and *Pacificare of Oklahoma v. Burrage*, 59 F.3d 151 (10th Cir. 1995), the plaintiffs alleged that the defendant HMOs were liable under state agency or vicarious liability theories for the malpractice of treating physicians. Both courts of appeal declined to apply a "complete preemption" doctrine to claims alleging negligent care by HMO plan doctors. The Third Circuit held that the quality of health care benefits was "a field traditionally occupied by state regulation" not preempted by ERISA. *Dukes*, 57 F.3d at 357. Likewise, the Tenth Circuit concluded that, because the doctor's negligence could be resolved without reference to the

ERISA-covered health plan, the claim "d[id] not implicate the concerns of ERISA preemption." *Pacificare*, 57 F.3d at 154.

In both cases, the conduct attacked by the plaintiffs did not involve a cost containment feature, utilization review or any other aspect of administration of an ERISA-covered health plan. Instead, the plaintiffs in *Dukes* and *Pacificare* merely alleged that the doctors misdiagnosed their patients, and that the HMOs should be liable for the doctors' negligent medical decisions because the HMOs arranged for and supervised the doctors. Nowhere in the two cases did the courts confront the question raised by the petitioner here regarding the impact of compensation arrangements on health care decisions. At most, *Dukes* and *Pacificare* stand for the proposition that HMOs may be vicariously liable for the medical malpractice of plan physicians —a claim that has not been alleged and has never been a part of this case.[2] Accordingly, the conflict in the circuits urged by the petitioner is illusory.

Indeed, the only other court of appeals faced with an issue similar to that presented in the petition decided the question in harmony with the court below. In *Corcoran v. United Healthcare Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1321 (1992), the plaintiffs challenged the conduct of an HMO in denying hospitalization for a pregnant patient who thereafter lost her unborn child. Because the HMO's decision was made "in the context of making a determination about the availability of benefits

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[2] If petitioner were to attempt to amend her complaint to allege a medical malpractice/vicarious liability claim against Medica at this late date, it would be barred by the two-year statute of limitations for such actions, Minn. Stat. § 541.07(1), among other defenses.

under the plan,"[3] the Fifth Circuit concluded that the plaintiffs' wrongful death action was preempted by ERISA. 965 F.2d at 1332. The Eighth Circuit followed *Corcoran* in this case and in *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir. 1993) *cert. denied*, 510 U.S. 1045 (1994). App. 34A.

The only state law causes of action petitioner has asserted against Medica are fraud, misrepresentation and tortious interference with contract. Petitioner's attempt to split hairs and revive these causes of action by now asserting that they challenge the "quality of care" provided is unsupported by any case law, and was never addressed by the trial court or Eighth Circuit below. Moreover, there is certainly no "conflict" in the circuit court decisions requiring review by this Court of petitioner's novel "quality of care" argument under ERISA.

C. Even if the Eighth Circuit had reached the merits of petitioner's arguments, Medica's actions fall entirely within "plan administration" under ERISA.

Petitioner's alleged causes of action against Medica relate directly to how Medica administered the Seagate Plan and how Medica disseminated information to Seagate Plan participants. As demonstrated above, petitioner has not alleged any cause of action against Medica directly challenging the quality of care provided to Mr. Shea by his physicians. Petitioner has instead claimed that Medica, in administering the Seagate Plan, failed to disclose the

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[3] The *Corcoran* court also distinguished other lower court decisions involving malpractice actions based on vicarious liability or agency rationales. *Id.* at 1332 n.16; *see Pacificare*, 59 F.3d at 153 n.2.

structure of physician financial arrangements. Such claims clearly implicate plan administration for purposes of ERISA. Indeed, while not presented with the exact "quality of care" argument raised by petitioner here, the Eighth Circuit in this case easily found that petitioner's claims against Medica relate to Medica's responsibilities as administrator of the Seagate Plan:

> Here, Medica administered Seagate's employee benefit plan, and Mrs. Shea maintains Medica wrongfully failed to disclose a major limitation on her husband's health care benefits. Along these lines, we have held that claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision.
>
> After considering the factors that guide our inquiry, we conclude the district court correctly decided that ERISA preempts Mrs. Shea's state-law claims. The outcome of Mrs. Shea's lawsuit would clearly affect how Seagate's ERISA-regulated benefit plan is administered, and if similar cases are brought in state courts across the country, ERISA plan administrators will inevitably be forced to tailor their plan disclosures to meet each state's unique requirements. This result would be at odds with Congress's intent to ensure "the nationally uniform administration of employee benefit plans.

App. 33A-34A. [Citations omitted].

It is well-established that claims arising out of the administration or coordination of benefits under an ERISA-governed plan are preempted by ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987); *see also Kuhl*, 999 F.2d at 302-303. Thus, the question here is whether Medica's failure to disclose the financial arrangements between the Seagate Plan and the physicians treating Mr. Shea falls within Medica's responsibilities to administer benefits under the Seagate Plan. Despite petitioner's assertions to the contrary, the few courts that have addressed similar issues have found that state laws addressing the substance of contractual agreements between ERISA plan administrators and medical providers "relate to" an ERISA plan. *See e.g., Cigna Healthplan of Louisiana, Inc. v. Louisiana*, 82 F.3d 642, 644 (5th Cir. 1996), (finding a preferred provider law preempted by ERISA because its requirements for contracts between ERISA plan administrators and providers operated as a mandate for ERISA plans to purchase benefits of a particular structure), *cert. denied*, 117 S. Ct. 387 (1996).

In *Cigna*, the district court addressed state regulation of contractual agreements between ERISA plan administrators and medical providers. The district court found that ERISA preempted a state "Any Willing Provider Statute" that required managed care firms to contract with any health care provider who was willing and able to meet the terms and conditions of their provider contracts. Noting that the statute "impacts the employers' or plan sponsors' discretion as to how health benefits may be structured under their employee benefit plans" because "[i]t explicitly directs that they may not structure their programs so as to exclude any provider willing and able to participate," the court concluded that the statute "affects the structure and

administration of ERISA plans, and therefore necessarily relates to such plans for preemption purposes." *Cigna Healthplan of Louisiana, Inc. v. Louisiana*, 883 F. Supp. 94, 103 (M.D. La. 1995). On appeal, the Fifth Circuit agreed with the district court and affirmed the finding of ERISA preemption based on the fact that the state statute impacted the administration and structure of ERISA plans. 82 F.3d at 648. Other courts have drawn similar conclusions.[4]

In addition, the United States District Court for the Eastern District of Virginia recently issued an informative and persuasive opinion on the issue of whether claims against an HMO for failure to disclose physician financial incentives are preempted by ERISA. *See Lancaster v. Kaiser Foundation Health Plan*, 958 F. Supp. 1137 (E.D. Va. 1997). *Lancaster* involved similar claims of negligence and fraud in failing to disclose alleged financial incentives that are comparable to the ones at issue in this case. *See id.* at 1148 n.31 (citing *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997)).

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[4] *See also Texas Pharmacy Ass'n v. Prudential Ins. Co.*, No. 95-50807, 1997 U.S. App. LEXIS 12986 *6 (5th Cir. Feb. 14, 1997) ("any willing provider" statute "relates to ERISA plans because it eliminates the choice of one method of structuring benefits"); *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir. 1993)(finding that a preferred provider anti-discrimination law "relate[s] to" ERISA plans but that it regulates insurance and is thus saved from preemption), *cert. denied*, 510 U.S. 1003 (1993); *Prudential Ins. Co. v. National Park Medical Center, Inc.*, 964 F. Supp. 1285 (E.D. Ark. 1977) (finding that Arkansas' Patient Protection Act of 1995 "relate[s] to" ERISA plans because, in part, it creates administrative burdens by "deny[ing] plan administrators the ability to deliver benefits through a limited network of providers and [by] the elimination of the gatekeeper"); *Blue Cross & Blue Shield. v. Neilsen, 917 F. Supp. 1532 (N.D. Ala. 1996) (*any willing provider statutes preempted by ERISA).

In *Lancaster*, the plaintiffs alleged an HMO, doctors, and the doctors' professional corporation "had in place a financial incentive program. . . whereby physicians receive bonuses for avoiding excessive treatments and tests." *Id.* at 1140. The plaintiffs alleged two counts of medical malpractice against the doctors, a negligence count against the HMO for its establishment of guidelines and cost standards, a negligence count against the doctors' professional corporation for its establishment of guidelines and costs standards, and a count against all defendants for actual and constructive fraud in not disclosing the alleged incentive program. *Id.* at 1140-41.

The *Lancaster* court concluded that it had jurisdiction over the suit because the claims related to ERISA. *Id.* at 1146-48. It then dismissed certain claims under an ERISA preemption analysis. The court dismissed all of the claims for the negligent establishment of an incentive program and for the intentional and knowing concealment of the existence of incentives. *Id.* at 1150. The court dismissed the direct negligence and fraud claims against the HMO. *Id.* The court dismissed the direct negligence claim against the doctors' professional corporation "for promulgating the Incentive Program." *Id.* The court also dismissed the fraud claims against the doctors and their professional corporation "for concealing the cost containment policy's existence." *Id.*

The *Lancaster* decision is a further example of the correct analysis under ERISA with respect to plan administration. Matters dealing with the disclosure of physician financial incentive plans clearly implicate plan

administration for purposes of preemption of state common law claims.

By challenging the substance of the contractual agreements between Medica and Mr. Shea's medical providers, petitioner directly challenges Medica's decisions in arranging for, structuring and administering ERISA benefits under the Seagate Plan. Such claims clearly "relate to" ERISA plans and are preempted under a straightforward ERISA analysis, as determined by the trial court and Eighth Circuit below.[5] Petitioner's arguments to the contrary are without merit, and certainly do not raise issues of significant importance requiring this Court's review.

D. Even if the Eighth Circuit had addressed the merits of petitioner's arguments, petitioner is not entitled to compensatory damages under ERISA § 502(a)(1)(B).

Petitioner also argues for the first time in her petition that if allegations relating to quality of care are preempted, she would be left without a remedy and, thus, this Court should fashion one under ERISA. Petition at 28. However, the existence of a remedy is irrelevant to the preemption analysis, and many courts have rejected arguments similar to petitioner's. *See e.g., Raymond v. Mobil Oil Corp.*, 983 F.2d 1528, 1537-38 (10th Cir. 1993) (recognizing that arguments that ERISA's preemptive or regulatory effect might deprive them of a remedy do not necessarily mandate

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[5] Because the state common law causes of action asserted by petitioner do not affirmatively regulate insurance within the meaning of ERISA's savings clause, the analysis of ERISA preemption ends there. *See Pilot Life Ins. Co.*, 481 U.S. at 48-51; *see also Kuhl*, 999 F.2d at 303.

that there be an ERISA remedy); *Corcoran,* 965 F.2d at 1333 ("while we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans, the lack of an ERISA remedy does not affect a preemption analysis"); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991), *cert. dismissed*, 505 U.S. 1233 (1992) ("nor is it relevant to an analysis of the scope of federal preemption that appellants may be left without a remedy"); *Hospice of Metro Denver, Inc. v. Group Health Ins., Inc.*, 944 F.2d 752, 755 (10th Cir. 1991)("we are aware that preemption normally is not dependent upon the availability of ERISA remedies").

ERISA is intended to provide one body of law to regulate ERISA plans in order to add stability, security and consistency to these plans nationwide. 29 U.S.C. § 1001(b). As part of this comprehensive approach to employee benefit plans, Congress established specific rights and remedies which may be asserted to enforce the Act's provisions. 29 U.S.C. § 1132. Additionally, this Court has held that extra-contractual compensatory damages are not available under ERISA. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256-58 (1993)("appropriate equitable relief" available under ERISA does not include extra-contractual compensatory or punitive damages).

Consequently, assuming petitioner had stated a cause of action under 29 U.S.C. § 1132(a)(1)(B), the only monetary relief she could seek is the amount equal to the benefit she claims was due under the terms of the plan. 29 U.S.C. § 1132(a)(1)(B). In this case, petitioner seeks extra-contractual compensatory damages for the death of her

husband, which are not allowed under ERISA. The fact that her remedy is limited to the terms of the plan is not relevant to a preemption analysis, and requires no further review by this Court. Again, it is also inappropriate for petitioner to raise such issues for the first time as part of her petition.

CONCLUSION

For the reasons given above, the petition should be denied.

Dated: September 4, 1997

Respectfully submitted,

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